August 2, 2004, Report

of the Statewide Planning Team for

Restructuring Geriatric Services

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Purpose of the Geriatric Restructuring Team

The Statewide Planning Team for Restructuring Geriatric Services (Geriatric Team) was initiated in August, 2003, to:

1) Review existing public mental health, mental retardation, and substance abuse services provided to geriatric consumers, with a focus on identifying areas that can be improved.

2) Review the current and projected needs for services to geriatric consumers, so that services can be planned accordingly.

3) Recommend improvements in geriatric services, and in methods for delivering needed services, based on objective data.

Given its broad scope, this undertaking will be a multi-year effort. The work is compounded by the fact that there is no comprehensive statewide plan that sets out a standardized continuum of specialized services for geriatric consumers. This means that there is no overall plan within which the geriatric restructuring team can fit its recommendations. We will have to take time to outline the components of what constitutes an adequate continuum of community-based geriatric services.

A more specific description of the tasks assigned to this team is provided in Appendix A.

Representation

The Geriatric Team includes broad representation of agencies, providers, and consumer groups involved with services to geriatric consumers. Members were chosen because of their specialized knowledge of and experience with geriatric needs and services, concern and advocacy for geriatric consumers, and willingness to work toward improving the services system. A list of members is shown in Appendix B.

Communication with Regional Restructuring Teams

Virginia has seven regional Restructuring Planning Teams that are addressing needs in their respective regions. The Geriatric Team seeks to coordinate its planning efforts with those of the Regional Teams. We are especially interested in communicating with the Regional Teams regarding:

1) What are the major problems and needs pertaining to geriatric services in their regions?

2) What issues or recommendations pertaining to geriatric services would they like to convey to the statewide Geriatric Team?

3) How would they like to be kept informed about the plans and proposals being developed by the statewide Geriatric Team (for example, receiving written reports versus having a Geriatric Team member give a report at their meetings)?

4) How can the recommendations from the Statewide Geriatric Team be integrated into their regional planning processes, if they are not already?

To these ends, representatives from the Statewide Geriatric Team will meet with each Regional Restructuring Team, at least once in this calendar year and thereafter to establish a mechanism for ongoing communication regarding ideas and initiatives that will address the needs of older adults throughout Virginia.

Initial Assessment and Planning

The Geriatric Team held meetings from August, 2003, to June, 2004. The team employed several methods to identify problems with the current system and recommendations for improving it. These included an analysis of Strengths, Weaknesses, Opportunities, and Threats (SWOT Analysis), and a survey of members to set priorities for improvement. Team members also discussed the restructuring project with consumers, providers, and agency staff throughout the past year and obtained their ideas regarding restructuring. The team then employed sub-groups to discuss key problems and develop ideas for improvement.

The team also emphasized the importance of applying a set of guiding values or principles. As a start, we endorsed the general principles set out by the commissioner in his overall guidelines for restructuring. We added nine more principles, drawing from work of the 1998 Hammond Commission, and the 1999 Surgeon General's Report on Mental Health. Through the Mental Health Association of Charlottesville and Albemarle County, two focus groups of geriatric consumers discussed and made suggestions regarding these principles. Although this list has not been finalized, we have a beginning list of principles that reflects the special needs of the geriatric population, and will be making refinements to it during the upcoming year.

Problems with the Current System of Geriatric Services

The Team identified the following as important problems with the current system of services that should be targeted for improvement:

<u>1) Geriatrics is an Under-Served Population.</u>

Less than one percent of the clients treated at the Community Services Boards are geriatric, even though geriatric patients make up perhaps 15-16% of the overall population. Unlike other special populations, the geriatric population has not received a systematic review at the state level to identify it as a priority population for delivering services at the Community Services Boards.

2) There is Inadequate Data for Planning Statewide Geriatric Services.

Very little data is available to quantify the statewide needs for geriatric services, or to systematically plan for future service needs. What data exists is fragmented, scattered among various agencies, and in different formats. This makes it difficult or impossible to compile into a useable form. Some help is on the way, however, since HJR bill 103 has now required a study during 04-05 of the increasing geriatric population and the impact on services.

3) Geriatric Services Are Split Among Many Agencies, and Poorly Coordinated.

While the Virginia Department for the Aging is the lead state agency on aging issues, many other agencies have an important role. Funding and services are not coordinated by any one agency, but are divided among many agencies. This leads to confusion for consumers, difficulty in access, gaps in services in some cases and overlapping services in others. Previously, the Department of Mental Health, Mental Retardation and Substance Abuse Services provided an Office of Geriatric Services; however, that division was eliminated through budget cutting, leaving no focal point for serving the geropsychiatric population and coordinating with other agencies.

4) The Lack of a Grand Plan for Geriatric Services Limits the Current System.

Geriatric consumers are not a priority population for services at Community Services Boards, and there are few specialized resources at these boards to provide for complex geriatric needs. No standard continuum of expected specialized services for geriatric patients has been provided to the Community Services Boards. Without a grand plan that sets higher expectations for geriatric services, and without funding to support the needed services, little will change. It's not that the Community Services don't want to serve more geriatric clients, it's that the resources they have are already overwhelmed trying to treat younger populations, so the needs of the elderly get lost.

5) There are not enough trained specialists to deliver services to geriatric consumers.

There are not enough professionals who have the specialized training required to meet the complex needs of geriatric consumers.

6) The Numbers of Caregivers are Insufficient.

Nursing Homes and Assisted Living Facilities do not have sufficient numbers of staff to manage residents with severe mental illness, or a combination of severe mental illness and dementia. Reimbursement rates available to these facilities are generally too low to enable them to provide the additional staffing or higher pay levels that are required to meet the demands of caregiving with these patients. Turnover is extremely high.

7) Caregivers to geriatric consumers do not receive adequate training and support.

Many caregivers in various provider agencies are operating at an inadequate level of knowledge and skill. This is a particular problem in long-term care settings where staff may be prepared to deal with medical problems but not mental illnesses. Staffing at many provider agencies is so thin that it is difficult to pull employees away from caregiving tasks long enough to train them. With high turnover, even those who eventually get trained move on to other jobs. The cycle of re-training staff is a continuing challenge, one

that often goes unmet. This results in substandard care. It also means that many geriatric consumers have to be moved to more costly and restrictive levels of care, because the numbers and skills of staff at lower levels of care are not sufficient to manage their conditions and prevent further deterioration.

While it has been demonstrated that providing support to these facilities by bringing in outside professional staff to help with assessments and consult on how to manage agitated or disruptive residents, such support is limited at best and unavailable in most cases.

8) Public and private funding are insufficient to create incentives for expansion of needed geriatric services.

Providers have to devote their resources to those priorities that are funded. New priorities will need to be set to promote the creation of needed services where gaps currently exist. And, new funding sources will be needed.

Virginia Medicaid eligibility criteria are strict and can limit the use of alternative care models. It is a positive sign that Virginia is now considering application of the PACE (Program of All Inclusive Care) model which can be used to provide more flexibility and serve more individuals in a community setting who would otherwise have to go into nursing homes. However, it will be important for the services system to better understand the limitations and potential of Medicaid funding, within the state's fiscal limitations.

9) Many elderly citizens in the general population experience acute psychiatric problems that go undetected and untreated, leading to deterioration in their condition which then requires more expensive treatment.

A significant portion of older adults in the general population (as many of 20%) experience episodic psychiatric problems including depression, anxiety, and other disorders. Research has shown that these conditions can be effectively treated. However, when treatment is not provided promptly or is inadequate to the needs, the problems typically worsen and often become chronic. This leads to an increasing number of people needing more intensive treatment, usually only available in the public system. The training of primary care providers (physicians and others) who initially respond to older adult needs is vital in identifying the onset of psychiatric problems and avoiding unnecessary long-term disability in this population.

General Recommendations for Improving the System of Geriatric Services

1) Develop a Master Plan for Geriatric Services, outlining a standard continuum of specialized services to meet the complex needs of geriatric patients.

This would include specifying the types, levels, and scope of services to be provided, expected programs and schedules, staffing, and funding requirements.

2) Establish additional community-based services to meet current unmet services needs.

Examples include adding geriatric specialists at Community Services Boards, and

creating more community-based residential treatment services that could be used as an alternative to more restrictive institutional placements.

An office or division should be created within DMHMRSAS to provide more focus and support for this effort.

3) Maintain state hospital geriatric beds.

Access to treatment at the state hospital is an essential component in the community-based continuum of services. The state hospital is a key resource that provides treatment to those patients who have exhausted all other alternatives and can no longer be managed in a less highly structured setting. We should continue to test alternatives that may be less costly or more community-based than the state hospital. However, the state hospital has specialized staffing and services that make it the only source of effective treatment for many patients. Coordination and planning between state hospital specialists and community providers, including the Community Services Boards, should be strengthened so that we can maximize community placements and community providers can access hospital staff expertise. This will help assure that state hospital geriatric beds are used most efficiently and as an integral part of the community-based continuum.

4) Quantify the increased geriatric services that will be needed at each level in the continuum of services, in response to a rapidly growing geriatric population that will approximately double over the next 25 years.

Then, continually expand funding, staffing, space, and services structures to handle the growing numbers of geriatric consumers.

5) Conduct extensive reviews of those approaches (model programs) that have been successful in providing effective treatment and quality-of-life to geriatric consumers and their families, so we can capitalize on those approaches in Virginia.

We should learn from how other states have structured their geriatric services, as well as from effective approaches used in our own state. The focus must be kept on objective results, not opinion or anecdotal observation. Recognition should be provided for staff operating effective programs, and information disseminated to promote use of the programs by others.

6) Develop standard data sets and reports that can be used in planning needed services, evaluating services outcomes, and making improvements.

Examples include population data to show current and projected geriatric population by various localities, data on availability of services providers by type and location, and data that reflects the comparative costs and outcomes of various services.

7) Maximize the use of Medicaid and Medicare, and grants in support of needed services.

We should look for increased flexibility in making the best use of available funding within federal guidelines, and also test new programs using demonstration grants when feasible.

It will be important for DMHMRSAS and DMAS to work collaboratively to identify strategies to remove barriers to funding needed community-based geropsychiatric services.

8) Provide ongoing coordination between the agencies delivering services to geriatric patients.

This should include joint planning, review of service delivery, collaborative problem solving, and continuing review of outcomes of services.

9) Inform and educate consumers and families about available services and entitlements, and how to access them.

It will require multi-agency efforts to organize needed information in useable forms, and get it into the hands of consumers.

10) Increase supports to family caregivers, to enable them to provide care to geriatric consumers as long as possible, reducing demands on public-provided services.

Family caregivers can keep geriatric consumers at home longer, but this requires that they get some help with the costs and daily demands of caregiving. Without help, family caregivers themselves often suffer medical or psychiatric problems from the overwhelming burdens of caregiving. With help, they can keep their elderly family member out of institutions indefinitely.

11) Strengthen training and continuing education of caregivers.

Research has demonstrated the effectiveness of training and ongoing education of caregivers. Results include improved quality of care, more effective and efficient caregiving, and reduced turnover of the caregivers. Additional efforts will allow us to identify where the gaps are in reaching caregivers with necessary training, and make better use of existing training resources to meet the needs.

12) Increase supports to long term care facilities.

Making geropsychiatrists and related mental health professionals available to Nursing Homes and Assisted Living Facilities can help them to manage residents with severe mental illness and dementia. Various studies have shown that such professionals can successfully support the facilities through either part-time or full-time involvement on-site. Through daily team effort with the facility, they can constantly update old and new staff on how to handle a range of demanding problems, and how to adapt their approaches to individual patients. Their ongoing, hands-on training and live supervision on mental health issues helps address staff support needs, and can lead to reduced burnout and turnover.

13) Develop partnerships with primary physicians and work through various agencies to extend continuing education to them, for the purpose of improving detection of mental illness and referral to specialists.

Physicians and other professional providers are highly trained, and work in demanding clinical settings. Planning effective continuing education has to be done in partnership with them, programs have to match their educational levels, and scheduling

has to be realistic with the demands of their practices. It will also be important to involve the relevant professional agencies and boards.

14) Develop a specialized focus on geriatric consumers having both mental illness and dementia.

The increasing number of consumers with a mix of mental illness and dementia calls for specialty training for both professional mental health providers and for direct caregivers in long-term care facilities. For that reason, it is recommended that this population be designated as needing the same specialty status and funding for training as other dually diagnosed populations.

Current Medicaid Mental Health Priority Population criteria do not provide for appropriate mental health treatment for persons with dementia alone, or with both severe mental illness and dementia. These criteria require that a person must have a diagnosis of serious mental illness prior to the onset of dementia to allow Medicaid reimbursement for mental health interventions. In reality, it is rarely possible to determine whether severe behavioral problems are due to the serious mental illness alone, dementia alone, or the interaction of the two. Current best practices require mental health interventions to manage many of the behavioral symptoms of severe mental illness with dementia, and of dementia alone. Recent changes in Federal Medicare reimbursement rules have been revised to recognize this problem and now pay for mental health treatment for these individuals. However, Virginia Medicaid criteria do not support proper care for this group of elderly persons with severe behavioral problems. The criteria need to be revised to reflect modern understandings of the origins of mental disorders as well as evidence-based treatment practices.

Specific Initiatives for 2004-2005

The larger task of the Geriatric Team is to work toward a Master Plan for Geriatric Services. However, this will take years to develop and implement. For the upcoming year, the Team plans to implement the following:

1) A Beacons Program

This effort will identify and recognize examples of model programs (or program components) operating in Virginia. The programs will be acknowledged and promoted.

2) Educational Program for Physicians

An educational program will be prepared, in collaboration with appropriate agencies and professional organizations, to reach primary care physicians and geriatric specialists who treat geriatric consumers. Support for the program will be arranged with the commissioner's office.

3) Compilation of Training Resources

Training resources that can be accessed by providers, consumers, and families will be compiled and organized by region.

4) Compilation of Geriatric Services

A directory of geriatric services will be compiled and organized by region. This will include descriptive information about available services, information on entitlements, and how to access services.

5) Obtaining Data for Planning

We will review existing databases that could be useful in planning geriatric services, and extract preliminary data for use by the Geriatric Team.

Detailed descriptions of these initiatives are provided in Appendixes C-G.

Strengths, Weaknesses, Opportunities, and Threats Related to Restructuring

As the Geriatric Restructuring Team was starting its work, we conducted an analysis to identify important strengths, weaknesses, opportunities, and threats related to the services system and restructuring efforts. The results are shown in Appendix H. This information is helpful in understanding some of the challenges with the present services system and attempts to improve it. We should capitalize on existing strengths of the system, as well as minimizing problems that undermine needed services to consumers.

Summary

Members of the Statewide Planning Team for Restructuring Geriatric Services reviewed the current services system, identifying key problems and developing a list of recommendations for improving the system. The team also developed plans for implementation during 2004-2005 to improve the system.

The team acknowledges that this is only a start. The larger need is to develop a master plan for implementing an adequate community-based continuum of geriatric services. This will require a multi-year effort, and the support of the legislature and all human services agencies. It will also require that we pursue new funding initiatives and funding incentives, as well as grants to help fill gaps in funding. With a rapidly growing geriatric population, this work cannot be completed too soon.

Appendix A

Tasks of the Statewide Planning Team for Restructuring Geriatric Services

This team is one of 5 special population groups (geriatric, mental retardation, substance abuse, children and adolescents, forensic).
The membership of this team will be broadly representative, to include consumers and family members, advocates, public and private providers, relevant partnering State agencies and other interested individuals.
Our scope will be State-wide.

Tasks:

- Consider previously made recommendations from a variety of state legislative and administrative studies and review best practices nationally and in Virginia, including the Olmstead draft plan;
- Review data that describes the special needs of and specific challenges associated with serving each population;
- Promote utilization of best practices and adoption of services that work;
- Develop recommendations for enhancing community models of care and promoting innovation;
- Explore opportunities to improve service delivery in communities and in state facilities, and
- Recommend strategies for enhancing collaborative relationships.

The team will develop short-term recommendations, as well as strategic plans that support long-term changes in how these populations are served in the Commonwealth.

Budget requests to support recommendations will be developed as appropriate.

We will provide written reports to the commissioner, which will be available to the public on the dmhmrsas web site.

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Appendix B

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Revised 6/15/04

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Appendix C

Beacons: Growth Through Positive Example

Statement of problem to be addressed

1. The spectrum of specialist mental health services for elderly Virginians is underdeveloped.
2. The development of a spectrum of high caliber, 'new look' services requires that we identify and encourage the best of modern innovations.
3. The key to success lies in recognizing and responding to our need to learn from our every day experiences and those of others around us.
4. To do this we must look to excellence for leadership and share, with others, examples of actual successes in improving our services, achieved largely through hard work.
5. This sharing of skills and expertise is especially challenging within a competitive environment.
6. To find useful guideposts illuminating the road forward, we may be well advised to examine some elements of models of modernization that have been found useful elsewhere.

Proposed initiative

1. The initiative proposes to conduct a pilot project. Its purpose is to identify and make known more widely, examples of the most innovate, effective and creative practice for older people with mental health problems currently operating within the State of Virginia.
2. This pilot will be conducted in a systematic and planned fashion, so that lessons regarding its utility can be drawn from the experience.
3. Following the processes of application by provider organizations and evaluation, a formal statement of recognition by the Commissioner for Mental Health, Mental Retardation and Substance Abuse, will identify individuals or organizations selected as outstanding.
4. The initiative will promote the sharing of information on best practices by funding those services or individuals identified as outstanding, to share their knowledge with others who seek to develop their own skills base and raise their own standards of performance.
5. The means of sharing expertise are under discussion but may include: the development of didactic materials; internet distribution; attending workshops, conferences, panels and other events; mentoring schemes; staff training placements and exchanges.
6. This model draws heavily on the United Kingdom 'Beacons' initiative, announced first in 1998/9 by the UK Department of Health and whose achievements are percolating now throughout the modernized National Health Service there.

Objectives

1. Appointment of an oversight and selection committee, including representatives of all stakeholders groups and services users;
2. Development of criteria for achievement. These include having demonstrated improvement through their outcomes; high quality service or practice recognized externally by financial or professional awards;
3. Development of processes for seeking, receiving and evaluating nominations;
4. Service providers and their umbrella organizations will be invited directly to submit applications. Also, those currently charged with the task of overseeing services and spending will be polled. Local and state government officials and others in a position to make such judgments, will be invited to submit nominations;
5. Site visits may be made;
6. Formal letters of recognition will be sent to successful applicants, as they are identified;
7. Nomination of successful applicants to membership of a 'first division' or 'premier league' network.

Target outcomes and how they will be measured

1. To prepare the field for change by altering expectations. Outcome will be judged by the number of applications seeking 'Beacon' status. An increase in interest among providers in pursuing excellence will indicate success.
2. To establish concrete, 'gold standard' examples against which to compare progress. Outcome will be based on the number and character of applicants adjudged to be worthy of recognition by the panel.
3. To strengthen patterns of good practice through reinforcement and stimulate creative activity through competition and example. Outcome will be judged by the willingness of the providers to invest in the process, including working together through the continuing process.

Time frame for implementation

The pilot program will be implemented and completed by December, 2005.
The exact timing of the various stages is not projected at this point.

Costs of Implementation

UNKNOWN. If the pilot program proves successful, the State of Virginia may wish to invest more heavily in the expansion of the recognition system, increasing the size and number of the grants available to Beacon organizations and practices.

Funding sources already available

No sources of funding are identified although some sources may exist that can be accessed via grant applications. However, it is known that many service providers are currently investing in national standards exercises such as CARF, in attempts to gain recognition. Success in one or more of these may be regarded indicative, if not conclusive, of attempts to promote excellence within an organization.

Funding requested
$50,000 for year 1.
During the first series of applications, up to 25 services or practices should be recognized. A budget of $2,000 should accompany the recognition of each Beacon. This award will be given to assist with the cost of preparation of materials or to defray expenses incurred in dealing with requests for information or assistance.

Impact on improving services, access, or cost efficiency
The entire exercise is targeted at improving performance of existing services and encouraging the development of high quality new services, in both the short and longer terms.

Data or literature justifying this initiative
The initiative in not cited directly by American sources but is supported by: Olmstead Recommendations for Geropsychiatry (# 42, 73); Achieving the Promise: Transforming Mental Health Care in America. Department of Health. (2003) Final Report of the President's New Freedom Commission on Mental Health. July. For direct references, including recent press releases see the United Kingdom Department of Health web-site (http://www.dh.gov.uk/PublicationsAndStatistics/ PressReleases).

Agencies that will support implementation of this initiative
At present the agencies supporting the initiative are those represented by the membership of the working group: Virginia Assisted Living Association; Fairfax County CSB; Region Ten CSB, Charlottesville.

Individuals Responsible for Implementation and Evaluation of Outcomes The responsible individuals are those signing off on this submission. At present they are: Larry Goldman, Richard Spector and Joseph Oliver. The support of the full Geriatric Restructuring Group is being sought.

Submitted by: Larry Goldman, Richard Spector, Jack Wood, and Dr. Joseph Oliver. June 18, 2004.

Appendix D

Family Practice and Primary Care Provider Education--Gero-psychiatry

Problem

There is a strong need to increase the number of family practice and primary care physicians who have access to geriatric mental health specialists in the Commonwealth. There is currently no statewide initiative to increase the numbers of physicians who are knowledgeable in this area or any initiative to increase the assessment skills and knowledge of geriatric mental health issues in the family practice and primary care arenas where access to the elderly population is the greatest. Increasing the knowledge base of family practice and primary care practitioners and encouraging appropriate referral of elderly patients to mental health care professionals will improve the early diagnosis and treatment of mental health and substance abuse in the elderly population. As noted in a statement in a press release by the American Psychiatric Association "The current system's failure to diagnose and treat mental illnesses takes a tremendous toll on seniors and their families". In recognition of that, a bipartisan group of legislators has introduced the Positive Aging Act of 2004, a bill that would fund projects that would integrate mental health services, especially early screening and appropriate referrals for follow-up care with primary care services in community settings. Rep. Patrick Kennedy (D-RI) in a capital hill briefing noted that 20% of older Americans who commit suicide did so the same day they saw their primary care physician.

Proposed Initiative

1) DMHMRSAS will formally communicate with major Medical Schools in the Commonwealth to encourage training of primary care physicians in mental health assessment and referral of the elderly to gero-psychiatric specialists.
2) DMHMRSAS will seek to improve identification of existing educational opportunities for primary care physicians in gero-psychiatric issues.
3) DMHMRSAS will create a workgroup comprised of representatives of facility medical directors, medical academic institutions and medical associations, to address the education and continuing education of specialists and primary care providers for older adults with mental health disorders.
4) DMHMRSAS will seek to enter into a cooperative endeavor with the Department of Health Professions, academic institutions, and other appropriate private medical organizations to assist in the distribution of gero-psychiatic training information and specialist information.

Objectives

1) To improve assessment and treatment of mental health problems in older adults through targeted education programs for primary care practitioners throughout the Commonwealth regarding the recognition of these problems and age-appropriate treatment modalities that have their foundations in evidence-based best practices.

2) To increase primary care physician awareness of the specialized needs of older adults in relation to mental health.
3) To increase the knowledge of primary care givers in accessing mental health services, recognizing that many older adults would be more comfortable with their primary physician than seeking out specialized mental health treatment on their own.

Targeted Outcomes and Measurement Techniques

Outcomes will be measured in part by the number of training opportunities identified; the number of family practice and primary care givers provided this information; and the Department will work with academic institutions and others in determining numbers of physicians accessing this training and provided referral information.

Time Frame for Implementation

The communication from the DMHMRSAS to academic institutions will be prepared and forwarded by late September of 2004.

The other activities are by their very nature fluid and thus will be ongoing.

Cost of Implementation

The cost will be to assist academic institutions and other medical organizations in mailing training and referral information and will be approximately $4,000.00.

Funding Sources Already Available

None identified at his time.

Funding Requested

$4,000.00.

Impact on Improving Services, Access or Cost Efficiency

1) Increased education of primary care providers would result in earlier intervention and treatment of mental health problems.
2) Encouraging the education of geriatricians, family care and primary care providers would facilitate referrals and decrease the waiting time for access to specialized mental health services, also encouraging the early assessment and treatment of mental health problems in the elderly.
3) Earlier recognition of all mental health issues, but especially depression, could decrease the rate of older adult suicide, which is twice the rate of the overall suicide rate.

Data or Literature Justifying these Initiatives

In 2000, 13 percent of Americans were over 65 years of age. This is expected to grow to 20 percent by 2030 as the "baby boomers" reach their later years. Nearly 20 percent of all Americans who are 55 years or older experience mental health issues that are not part of the normal aging process and this is thought to be an under-representation of the actual number of older Americans with mental health issues. In addition, the

suicide rate among older adults is higher than in any other group, with those over 85 having a suicide rate more than twice the average population (American Association for Geriatric Psychiatry, 2004).

Even though they are 13 percent of the population, older adults account for only 7 percent of inpatient psychiatric care, 9 percent of private mental health care and only 6 percent of community mental health services nationally. Generally, the first person an older adult consults on mental health issues is their primary care practitioner. Without additional education and or training in the mental health issues of the elderly, these practitioners may not have the skills needed to provide adequate assessment. Many older adults assume that sleep disturbances and appetite changes are a physical problem, which is inadvertently reinforced by primary care practitioners who do not have the time to complete a detailed medical and social history that might bring depressive symptoms to light. 20 percent of elderly suicide victims had seen their primary care physicians within 24 hours of their suicide, 41 percent within 7 days and 84 percent within 30 days (Persky, 2004).

The assessment and diagnosis of older adults with mental health problems is complicated by several factors. The clinical presentation may be different from other adults and older adults may express symptoms that do not meet the clinical threshold for a diagnosis. Further, many mental health issues are clouded or obscured by co-morbid medical conditions (NIH Consensus Development Panel on depression in Late Life, 1992). Also, older adults are more likely to express symptoms in somatic terms, which also leads to under-identification of mental health issues (Blazer, 1996).

It is estimated that only one half of older adults who will admit to mental health issues receive treatment from any healthcare provider. Only 3 percent receive any specialized mental health services (Lebowitz, et al, 1997).

Agencies that will Support Implementation of this Initiative

The Department of Mental Health, Mental Retardation, and Substance Abuse Services
Virginia Commonwealth University Medical Center
University of Virginia School of Medicine
The Virginia Department for the Aging

Individuals Responsible for Implementation and Evaluation of Outcomes

The Department of Mental Health, Mental Retardation, and Substance Abuse Services

Appendix E

Compilation of Training Resources

Problem

There is currently no system for consistently informing service providers and families about the information and training resources available to them.

Knowing and using available resources could help them better understand various aspects of mental illness and increase their effectiveness as providers of assistance and care to elderly family members and clients.

Proposed Initiative

The Education of Family and Providers work group proposes to develop a directory of sources of training and information, to be made available to both providers and family members.

This directory will *not* include available services or entitlements, which is being compiled by another work group.

DMAS has provided a "Road Map to Services" which provides a statewide listing. Our directory might be similar in format, but would need to focus on resources within given regions or localities.

All or parts of the directory will be put on multiple web sites, for ease of access. There will also be a written directory, since some do not use web sites.

Objectives

1) For each mental illness occurring in geriatric consumers, providers and licensing agencies will be able to access web sites, organizations, printed educational materials, and training programs available for use in educating caregivers about a) the nature of the diseases, and b) methods for delivering effective care and managing various challenges related to the diseases.
2) For each mental illness occurring in geriatric consumers, elderly persons and family members will be able to access web sites, organizations, printed educational materials, and training programs available for use in educating themselves about the diseases. Family members in a support or caregiving role will also be able to access information to help them perform those roles.
3) Providers, families, and consumers will also be able to identify the various agencies that provide services to mentally ill geriatric clients, and the roles of those agencies.

Target Outcomes and How they Will Be Measured

a) A written directory will be distributed to providers, licensing agencies, families. This may have to be split into separate directories, specific to different audiences. The directory will include web sites that are useful for obtaining information; however, other ways to obtain information will also be provided, since not all will use web sites.
b) Measures of success will include a) numbers of directories distributed, and b) feedback about usefulness from a sample of those receiving the directories.

Time Frame for Implementation

Time frames are tentative, and will have to be adjusted based on student availability.

Aug04	Work with college or university to identify a graduate student who could contact agencies and compile the directory Plan A is to arrange this with VCU, possible School of Social Work or Gerontology Plan B would be VPI (second choice because of distance)
Aug04	Work Group meets with the student and faculty member to outline expectations and develop a work plan and schedule for reporting
Aug-Sep04	Student queries agencies to obtain relevant information Student explores possible web sites for listing information for access by providers and family (Senior Navigator is one possibility)
Sep-Oct04	Work Group has follow-up meeting with student/faculty to discuss progress, provide additional guidance as needed Work Group starts planning who can format information for web sites, and how written directory can be copied and distributed
Dec-4	Student compilation of directory information completed Work Group meets to review and plan next steps
Jan-Jun05	Work Group arranges for copying and distribution of directory, and plans to get feedback from a sample of users

Costs of Implementation

We can only provide rough estimates at this point. These estimates will need further specification and substantiation.

$500	for work group to reimburse student as needed for copying materials or incidental expenses
$10,000	for formatting information to be placed on web sites
$20,000	for copying/printing directories

Funding Sources Already Available

None

Funding Requested

Funds are requested from DMHMRSAS to cover the implementation costs listed above, and should be paid and accounted for by that agency.

If funding cannot be provided by DMHMRSAS, the Work Group will seek help from the larger restructuring team or other sources in finding a grant, or other state, local, private agencies that might fund the project.

Impact on improving Services, Access, or Cost Efficiency

1) By accessing available educational materials and training resources, providers will have better educated staff, more skilled in caregiving, and better able to prevent unnecessary institutionalization of consumers.
2) Similarly, consumers and families will be able to get information that will enable them to manage more on their own and find needed support at an earlier stage, and thus prevent unnecessary utilization of public or private mental health services.

Data or literature justifying this initiative

We do not have quantitative data to describe the extent of the problem being addressed, or to substantiate a need for this initiative.

However, the initiative is directly supportive of the goals of the President's New Freedom Commission on Mental Health (See Achieving the Promise, July, 2003), including:

1) Understanding mental health and addressing it with the same urgency as physical health
2) Involving consumers and families in control of services
3) Obtaining early assessment and access to services
4) Using technology to access mental health care and information

Additionally, education of providers, consumers, and families has been identified as a priority by the geriatric restructuring planning team.

Agencies which Will Support Implementation of this Initiative

Agencies represented by members of this work group are willing to support the project (VHCA, Alzheimer's Association, Senior Connections, Social Services, DMHMRSAS).

Individuals Responsible for Implementation and Evaluation of Outcomes

The Work Group on Education of Providers and Families.

Additional Information

<u>TOPICS We Are Seeking in Available Educational Materials or Training Programs</u>

Examples include the following (this is not an all-inclusive list):
Mental Disorders in the Elderly
Understanding and Managing Problem behaviors
Dementia and cognitive impairments
Medications, Interactions, and Adverse Reactions
Development and implementation of meaningful activities
A family guide to agencies and services
Special care units
How to choose an assisted living facility
Role of different agencies (CSBs, Area Agency on Aging, Vista, APS/DSS)
Awareness of the various advocacy groups:

- Ombudsman
- AAA
- VOPA
- APA
- Alzheimer's Association
- Senior Connections
- ARC
- VAMI

Organizations to Be Contacted (include national, state, and local agencies):

Alzheimer's Association
Senior Connection
NAMI
National Family Caregiver Association
American Psychiatric Association
American Psychological Association
Geriatric Case Managers Association
NIH
NIA
NIMH
NASW
ADEAR
PGI (and other state facilities)
Colleges and Universities
State Disease Commission
INOVA

Persons to contact as a resource:

There many individuals who could advise or provide help with this project. Initially, we want to contact Karen Roberto (Va Tech), Connie Coogle (VCU Center on Aging), and Howard Cullum. Additional contacts will be identified later.

The contact at VCU for obtaining a student is Dr. Bob Schneider. Karen Cullen will contact him to explain the project and arrange a meeting sometime in late summer. Another source at VCU is Dr. Iris Parham in the Gerontology Dept.

Appendix F

Compilation of Geriatric Services and Entitlements

Statement of problem to be addressed

There are many barriers to the early treatment and care of older people with mental health problems. One important one is a lack of knowledge by the general public concerning the availability of suitable local services. Individuals and their families are slow to identify what services are available to meet their particular needs, and to initiate timely contact with a service situated close to where they live. In some cases, delays lead to tragic consequences for individuals. At present, there is no familiar and reliable compilation and guide to existing resources to improve mental health. Service users need to know where and how to get the right treatment, care and benefits!

Proposed Initiative

This initiative proposes to create a compilation of local specialist services that target older Virginians with mental health conditions. Also, the exercise requires the existence or production of a document describing the core services specific to this patient population, presented in the form of a 'User's Guide to Accessing Services and Benefits'. Thus, the completed document will contain details of services, organized by locality, and a description of core services for consumers, mapping the steps necessary to access these with the least delay.

Objectives

1. To identify the range of resources necessary to improve, maintain or reinforce the mental health of older consumers;
2. To apply a consumer centered model and its elements of independence, maintenance, integration, rehabilitation, resettlement, treatment, support, psychological treatment, care coordination and respite care;
3. To identify available services, including those that support care-givers and friends;
4. To provide information that enhances the capacity of individuals, families, caregivers and professionals making referrals, to overcome barriers to care and facilitates access;
5. To support longer-term efforts because as a result of this project we will learn what needs to be done to disseminate information and promote choice.

Target outcomes and how they will be measured

Each stage of the project (given below) will be monitored and recorded, with periodic reports made to the full Geriatric Restructuring Team for evaluation. The entire project will be completed on time and within budget. Also, it is anticipated that success will foster improved consumer access to mental health services for older people in Virginia, strengthening the relationship of consumers to their services. Eventually, this will contribute to shorter waiting periods for first appointments, and reduced no-show rates for first appointments.

Time frame for implementation

The project will involve the following stages and timeframe:

1. Aug., 2004	Establish a steering committee to undertake the project;
2. Oct., 2004	Acquire adequate resources to stage the project;
3. Oct., 2004	Commission a 2 stage search of the existing provisions from an internet firm (e.g. SeniorNavigator, Richmond, Va.) that maintains an extensive, current data base of agencies, facilities and licensed professionals across the state; *Stage 1:* Using selected keywords, an extensive database of specialist services in Virginia will be queried. Parent organizations will be identified and categorized by locality. Examples of selected services can be given. Standard paper output will be provided. *Stage 2*: Using more complex search procedures, the details of every appropriate service will be examined (i.e. 1,900+). Key concepts will include those elucidated above (see: Objective 2). Also, search will reveal other directories that may be of use. Output will be received in a form compatible with the production of the final report.
4. Oct.-Nov., 2004	To work closely with the chosen firm to refine search parameters;
4. Jan, 2005	To receive and analyze the results of the search;
5. Jan.-June, 2005	To organize a compilation prefaced by a 'User's Guide to Virginia's Mental Health Services for Older People', based on the search results and other available information;
6. July-Dec., 2005	To oversee the production of a suitable document in printed form;
7. Dec., 2005	To work with existing provider, consumer and government networks existing within the State of Virginia to make the resulting 'Compilation and User's Guide to Services' available to the public in an attractive, useful form(s). Dissemination via the internet should be considered.

The final report will be available to the Geriatric Restructuring Team by July, 2005, and the published report to the general public by December, 2005.

Costs of Implementation

The total costs of the project are $20,000.
If the compilation and guide is updated in the future, additional costs may be required.

Funding Sources Already Available

Considerable resources in the forms of staff time and expenses are being made available to this project through the organizations that support the Geriatric Restructuring Team. At present these include: Senior Connections, Richmond; Virginia Center on Aging, Richmond; the Alzheimer's Association; Piedmont Geriatric Hospital, Burkeville and; Region Ten CSB, Charlottesville. If commissioned, Senior Navigator will absorb some of the cost and undertake the Stage 1 search work *pro bono.*

Funding Requested
$5,000 to fund Senior Navigator for Stage 2 (i.e. www.Seniornavigator.com); $15,000 for preparation and printing of final report. Total budget $20,000 (2005).

Impact on improving Services, Access, or Cost Efficiency
An essential early step in restructuring Virginia's mental health services for older citizens is to make clear to all involved, legislators, citizen users, professionals and mangers, the range of current services and how well these match to what should be available. More clarity in this respect will foster confidence in any process designed to transfer resources or summon additional resources.

Data or literature justifying this initiative
There are no direct references to this initiative in relevant state documents. However, its need is clear and well supported by other recommendations in Olmstead Recommendations for Geropsychiatry (# 36, 56, 64, 128, 131) or; Achieving the Promise: Transforming Mental Health Care in America. Department of Health. (2003) Final Report of the President's New Freedom Commission on Mental Health. July, p. 16-18.

Agencies that will support implementation of this initiative
Senior Connections, Richmond; Virginia Center on Aging, Richmond; Region Ten CSB, Charlottesville; The Alzheimer's Society, Va. and Piedmont Geriatric Hospital, Burkeville, Va.

Individuals Responsible for Implementation and Evaluation of Outcomes
The application is submitted by members of Geriatric Restructuring Team, acting on behalf of the entire group. The Team will approve the membership of a steering committee. They will undertake project organization, management and production of the compendium/guide and ensure that the project completes its work on schedule, within budget and that probity is observed.

Members
Dr. Ed Ansello, Dr. Thelma Watson, Dr. Bob Lewis, Mr. Carter Harrison, Dr. Joe Oliver and staff.

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Appendix G

Obtaining Data for Planning

Need

Data will be the foundation for explaining and justifying all efforts to make improvements in the structure of the geriatric services system. The restructuring team needs data to:

1) Describe the size and characteristics of the statewide geriatric population and sub-populations to be served. At minimum, this will include breakouts for age groups 55+, 60+, and 65+ in the general population, and 50+ for the prison population (since we receive forensic patients and need to project numbers coming from the prison system).
2) Identify, quantify, and prioritize consumer needs, so that the appropriate mix of services can be matched to those needs
3) Identify, quantify, and prioritize resource needs, to support delivery of needed services
4) Identify quantitative measures that can be used to evaluate outcomes
5) Quantify service outcomes, to evaluate efficiency and effectiveness
6) Describe provider agencies and services available to meet service needs
7) Describe and compare costs of delivering needed services, both for budgeting and for measuring relative efficiency of alternative ways to deliver services
8) Describe variability in the above variables, by region, locality, and providers, so that resources can be matched to varying needs and allocated to the most efficient providers
9) Estimate projected changes and trends in the above variables, so that resources can be adjusted accordingly.
10) Develop decision guides for selecting available services

Problem to Be Addressed

Currently, data for the above purposes are not available to the restructuring planning team. Although there are some relevant data sets that might be useful to us, those data are scattered across various agencies. No system is in place for us to access the data, extract useful data elements, or determine how reliable and valid those data are for our purposes.

Proposed Initiative for 04-05

The restructuring team will develop one or more data sets that can be used for the needs listed above.

In the short-term, the Data Work Group will:

1) Identify and describe existing databases in various federal, state, or local levels that could be useful.
2) Select data from those databases (to the extent that agencies can give us access) and use it in our planning.

3) Start accumulating a list of data elements we would like to have, and descriptions of how those elements will be used in our planning.
4) Develop a basic data set for our purposes, and collaborate with state agencies to obtain this data in consistent formats.

Long-Term Development

Long-term, we need to develop standard extraction routines that can periodically pull updated information from various agency data sources, to be combined and reported for our specified applications.

It will probably not be feasible for us to develop and maintain a comprehensive database of our own, but we should be able to draw on relevant databases already being maintained.

Objectives for 04-05

1) General Population Data -- The restructuring team will have a written set of standard data elements and reports for use in describing Virginia's geriatric population, broken out by locality, with unique individual identifiers so that population data can be combined with service data from other data sources for use in predicting and planning to meet needs.
   a) Review the census data VDA has already provided us to see how it can be used. If additional census data are needed, we will identify the specific data elements needed and work with VDA to derive that data.
   b) Summarize findings from the data (for example, to regional planning groups) to get feedback on usefulness, and then refine the data elements and report formats.

2) Population of Geriatric Mentally Ill -- The restructuring team will have a written list of standard data elements and reports to be used in describing geriatric patients in Virginia with mental illness, broken out by locality and type of residence (NH, private residence, ALF, hospital), again with unique individual identifiers for the purpose of combining data from multiple sources.

3) CSB Service Data -- The restructuring team will have a written set of standard data elements and reports to be used in describing geriatric patients served by CSBs, also with unique identifiers.
   a) Work with DMH to develop a routine for extracting the data from the Community Consumer Submission database.
   b) Present initial findings from the data, and get feedback to use in refining the data elements and reports.

4) Data on Providers -- The restructuring team will have a written set of standard data elements and reports to be used in describing service providers at different levels, by location, by service type, by capacity, or other factors.

5) List of Data Needs -- The restructuring team will have a beginning written set of additional data elements (beyond what we have identified as already available) that we would like to have for identifying needs, allocating resources, planning services, and evaluating outcomes (NASMHPD may be able to help). This will include a description of how the data would be used.
a) Contact NASMHPD Research Institute to see what help they can provide, and explore what data they have or data they might help us access, relevant to our purposes.
b) Similarly, contact other state MH agencies.
c) Look for agencies that could provide the data, or plan small studies to collect the data.
d) Review preliminary data on needs and unmet needs, available from JLARC in October.
e) Explore other data sets for potential use, such as the Medical Expenditure Panel Survey, and Medicaid and UAI data at state and national level.

Target Outcomes and How they Will Be Measured

1) Outcomes will be written reports for each objective.
2) One Measure will be the restructuring team's assessment of usefulness.
3) Another Measure will be the number and types of uses we make of the data.

Time Frame for Implementation

The following schedule is a rough approximation, and will vary depending on availability of team members and the agencies we are working with, and the level of difficulty we experience in accessing data in usable formats from existing sources. There can be tremendous technical difficulties and labor hours involved, which we cannot predict.

Sept04	Contact/visit NASMHPD to review available data sets and seek advice for our project
Oct04	Review and describe data available through DMAS or CMS
Nov04	Review the CCS data submissions to DMH Identify geriatric data elements, and compile initial reports
Dec04-Jan05	Prepare summary of census data available to us through VDA Identify any additional census data needs, and a standard method for extracting the data
Jan-Sep05	Describe data available to depict incidence of types and levels of mental illnesses among geriatric population Present selected data to full geriatric restructuring team and get feedback Present selected data to regional restructuring teams and get feedback Begin describing needed data elements, and possible sources for extracting the data

Jan-Sep05	Describe data available (and needed) to depict availability and location of service providers and the types, levels, and costs of services they provide
Jun05	Preliminary report to the Geriatric Restructuring Team to summarize progress made and limitations experienced so far
Oct05	Final report including: 1) Accomplishments so far, and 2) Plans for the Next Phases of Development

Costs of Implementation
For this year, the main costs will be the time contributed by the Data Work Group and by agency staff who help us pull together existing data.
A secondary cost will be the travel expenses of the Data Work Group.
$2,000.00 should cover the cost of member travel to meetings, and possible trips to NASMHPD or other sites to review their approaches to Data Collection and Utilization.

Funding Sources Already Available
None.

Funding Requested
$2,000.00

Impact on improving Services, Access, or Cost Efficiency
Data obtained can be used as a basis for justifying system improvements.
Data on service delivery costs can be used in improving efficiency.

Data or literature justifying this initiative
The fact that there is no current useable database for our purposes provides the justification for developing it.

Agencies which Will Support Implementation of this Initiative
Those agencies represented by the members of the Data Work Group.

Individuals Responsible for Implementation and Evaluation of Outcomes
The Data Work Group, of the Geriatric Restructuring Team.

Appendix H

Statewide Planning Team for Restructuring Geriatric Services

SWOT ANALYSIS
(Strengths, Weaknesses, Opportunities, Threats)
August 29, 2003

At its meeting on August 12, 2003, the team began a SWOT analysis (discussion of strengths and weaknesses in the current system of services, and opportunities and threats related to restructuring efforts). After the meeting, members completed an individual SWOT analysis. These were compiled into the summary that follows.

STRENGTHS

1) Strong hospitals/staffs/commitment focused on target population.
2) State Hospitals carry Medicaid funding.
3) Many interested agencies and groups willing to join in.
4) Likely a pretty involved family constituency among patients.
5) It's a system problem we know long and well!
6) Currently facilities have full time medical and psychiatric staffs allowing for crisis intervention and medication adjustment; interdisciplinary team approach.
7) The existing state facilities and their staff, as well as state facilities that are geropsych oriented that can be used as a regional hub for providing care. This includes but is not limited to inpatient, and would include education, training and consultative services, enhancing their value to the community (and to the Governor and General Assembly!) while reducing the stress on inpatient bed census capacity.
8) Trained professional staff present in existing delivery sites.
9) Quality of care does not appear to be compromised.
10) Medicare/Medicaid funding perceived to be adequate for existing patient population in the four hospitals.
11) Facilities that have professional experience with this population.
12) Community programs that also have some professional experience with this population.
13) Successful professional work in other states to learn from as we plan.
14) Commitment to do this with a value-centered approach.
15) Some databases that could be of benefit to understand the extent of our issue.
16) The existence of several large hospital facilities dedicated to serving this population suggests substantial available clinical expertise and financial resources with which to resource or support a new service. In addition, local CSBs are gearing up for change, some making appointments to facilitate and coordinate developments for elderly services.

17) The experiences of developing community care against a background of the rundown of the historic long-stay mental hospitals gives invaluable guidance of how to manage change successfully. Also, services for the elderly mentally ill exist that are being and/or have been evaluated. Where effective, these novel services can provide examples of best practice upon which others can look for inspiration and practical advice.
18) There is a strong educational infrastructure scattered throughout the state. This includes a range of centers for higher and continuing education that are able to conduct the training and research needed to support an ongoing program of service innovation and modernization.
19) There is plenty of evidence of partnership arrangements working successfully for mental health at the local level. Everyone has been brought to the table and in ways that ensure that their voices are being heard. These arrangements span the public, private and voluntary sectors and involve local politicians. With encouragement, they may serve as the basis for developing strategic alliances among local providers. These alliances enhance the possibility for achieving a seamless, integrated spectrum of joined up services within the community.
20) It seems a political reality that the middle and upper classes in our society are aware of the issues surrounding an aging population, including mental health, as they begin to impact directly on them. Their concerns are key drivers to change.
21) Strong state facilities.
22) Strong CSB's.
23) Experienced, able people from various agencies and stakeholder groups who are willing to advocate for and help implement constructive changes.
24) Excellent Medical & Psychiatric care.
25) Excellent oversight, by VOPA, APA, JCAHO, IG.
26) Adequate staffing in direct care.
27) Knowledgeable, well-trained staff.
28) Physicians who are specialized in Geriatrics.
29) Positive political support.
30) EVMS Center for Excellence.
31) PGH Institute for Community Training (Piedmont Geriatric Institute).
32) State facilities such as PGH and Catawba are a strength of the current system.

WEAKNESSES

1) CSBs are missing some needed resources, especially RE geropsych.
2) Limited resources for Recruitment & Retention.
3) Public image/Stigma of Mental Illness.
4) Tremendous scrutiny by outsiders (VOPA, IG).
5) Staff turnover in all areas.
6) Decreasing resources through mandated productivity savings.
7) Political uncertainty: changes in philosophy.
8) Lack of AR's/Guardians.
9) No cost of living increase to match reductions.

10) Not enough flexibility in state facilities to use “common sense” approaches to care.
11) Fear of lawsuits if using natural substances or alternative therapies.
12) Too many meetings, regulation, and paperwork in facilities to leave time to spend with patients.
13) Communities facilities not equipped to care for severely demented patients, either in NH or ALF.
14) Community facilities do not have needed medical, nursing, and support staff.
15) Pharmaceutical and insurance industries have too much control over care provided.
16) Society often ignores mental illness.
17) No geriatric services at some CSB’s.
18) Dispersed organizational structures and services.
19) Insufficient community services for those leaving hospitals.
20) Target population is particularly fragile/unstable – and not as well understood by practitioners outside this specialty area.
21) Advocacy groups tend to be splintered and focused narrowly while the target population is "hybrid" in nature .
22) Target population probably not as "attractive" to general public for investment because it has little prospect of improvement in the sense of increased productivity or true independence.
23) Lack of community beds to address crisis situations, lack of trained staff in the community, it is difficult to place a patient back in a nursing home after a crisis.
24) Weaknesses are the current reimbursement schedules, which do not provide incentives toward a continuum of care.
25) Lack of data to know the current and projected need for these services.
26) No current assessment of available community resources throughout the state to provide services for this population.
27) Protection of status quo; resistance to change.
28) Lack of organized plan and commitment to the provision of quality services closer to where people live or expand the types of services available in the community.
29) Financial constraints which may inhibit development of alternate service site.
30) Lack of clarity on amount of resources available and how much we need to address the problem.
31) Lack of understanding on extent of needs of our population, and the challenges in delivering services.
32) Lack of clarity on what level of care and services are needed.
33) Lack of database that has data validity and data integrity that we can immediately build upon.
34) Presently, no network of ‘backup’ community services, able to deal with more complex and challenging cases, is available for the non-specialist residential and health facilities caring currently for many elderly mentally ill. That appears to be regarded as a role for hospitals.

35) We are in a climate now, nationally and locally, that holds firmly to the notion that localities should 'take care of their own'. However no remedies are apparent for helping localities to fund this responsibility to a satisfactory level.
36) Following from the above, CSB delivery systems are closely linked to perceived local need. While producing welcome sensitivity and diversity, it may be difficult to assure equal access to or quality of care and treatment across the community or for the civil service to implement a unified system of oversight that can produce consistent improvements.
37) Competency among community based professionals needs to be increased from its current baseline to assure adequate standards of service. For example, additional education and a multidisciplinary team approach to providing care for the elderly mentally ill may be attractive for primary care providers, upon whom so much will depend.
38) It is unclear that a pool of trained local managers exists who are adequate to the task of providing leadership in a time of change. These might have to be developed early on in a process of modernization.

OPPORTUNITIES

1) Considerable latitude in the Reinvestment initiative.
2) A certain amount of political guilt may exist because of previous cuts in the system.
3) To engage in research through the Center for Excellence in Aging and Geriatric Health (at EVMS) and to train staffs at other facilities (nursing homes) in treatment and general best practices.
4) The current environment of reinvestment/restructuring, which opens the possibility of initiatives that might not be considered in a more cushioned financial context.
5) Commitment to plan ahead for this population.
6) Commitment to allocate resources to this population.
7) Put plainly, everyone knows that the system is broken. Because everyone knows this, an opportunity is afforded to improve the situation.
8) The availability of new finance should stimulate growth in type and quality of services. This is an opportunity to get the entrepreneurial instincts of the provider sector harnessed and active. A chance exists to stoke up the mixed economy of care. One might exist also to coordinate, integrate or simplify disparate purchaser functions, thus reducing costs.
9) A chance exists to open the debate about compulsory treatment orders. This is not simply about control and compliance in treatment to reduce risk, although that is certainly a part of it. It is about mandating and provisioning adequate packages of care, based on assessed need, by the local communities. This is a good opportunity to engage consumers and their families in the planning process.
10) It follows that there is a chance to legislate to improve the standards of care found in residential homes. Perhaps this will happen through the inspection process as well as utilizing benchmarking and peer review as means of identifying training needs and driving up quality.

11) A chance exists to influence professional training and qualifications within the state. New, innovative training packages, delivered in close association with the service providers can be grown and tested. Matters of recruitment and retention may be addressed.
12) A chance exists to stimulate research on the issue of the elderly mentally ill, that will inform service development and assist in the task of monitoring and evaluating service delivery. This growth should provide many opportunities to promulgate innovations and to gain recognition for successes derived from following a new investment strategy.
13) Following on from the above, a chance exists to examine the adequacy of the state/national core minimum data set and make adjustments. These adjustments might reflect changes in commissioning focus away from processes and incidents towards outcomes or the introduction of new technologies.
14) Mental illness in the elderly, as with physical illness, is strongly determined by lifestyle. Planning new style services cries out for the integration of a public health approach into mental health. More attention needs to be given to the collection and use of epidemiological data and to primary prevention strategies as means of minimizing longer-term risk factors.
15) To identify resources that could help fill gaps in available community services.
16) To get process, cost, and outcomes data that could be used to better manage available resources.
17) Consolidation of resources among populations.
18) Use of Data to support outcomes.
19) Implementation of new clinical systems.
20) Political support from Baby Boomers.
Possibility of having 2 geriatric facilities instead of 5.
21) To educate doctors in diagnosis and referral.
22) To educate caregivers of all types and families in signs of dementia, and appropriate use of medications.
23) To promote use of alternative therapies, to cut costs and improve care.
24) To communicate with legislators about what is needed.

THREATS

1) No money -- and lots of competition for what money there is.
2) Not a lot of maneuverability in federal regulations/funding streams.
3) Fatigue factor -- advocates and agencies have tried and failed often.
4) Sheer magnitude of the problems, which grew as they went un-addressed for so long, may engender a sense of hopelessness about putting great effort into yet another plan.
5) Costs- hospital is more expensive than a nursing home. However when all medical costs, e.g., crisis intervention, are considered it may not be.
6) Threats are that entropy will prevail.
7) Not enough resources to address the need.
8) Maintaining trust and credibility in the planning process.
9) Maintaining and creating resources as the need increases.

10) Threats are the most important but least understood element in the equation. Nevertheless, it is frequently the unknown or unexplored variables that scuttle change.
11) The threat exists with re-provisioning that appropriate safeguards will not be in place when changes happen, that untoward events will occur and that scandal and public backlash will ensue. We have seen this occur sometimes with community care for the adult mentally ill. Civil servants, charged with providing cover to elected officials, may wish to consider this.
12) Examining the matters of civil liberties and mental health may prove divisive. This risk should be mitigated if all-party consensus is sought.
13) The current market may not evolve sufficiently to deliver the goods for a new style service.
14) Inadequate analyses, derived from poor information, may lead to poorly targeted services.
15) Finally, one can presume that the elderly mentally ill are not a traditionally high priority group. The threat exists - doubtless remote - that reorganization may only serve as an unwitting vehicle to divert resources away from mental health.
16) Limited time and resources to invest in this effort.
17) Possibility that policymakers will focus only on restricting expenditures.
18) Possibility that policymakers will focus only on what sounds good "politically" and not address what is actually needed.
19) Possibility that all the focus will be on immediate, short fixes, with no longer term planning to address projected needs for the future.
20) Threat of Closure of facilities.
21) Continued reduction in appropriations.
22) VITA – no IT services.
23) Medical rate reductions.
24) Increasing populations.
25) Increasing medical needs.
26) Increasing drug costs.
27) Infrastructure needs for geriatrics.
28) No beds ultimately available – Full.